

U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)



Issue Date: 26 September 2013

Case No.: 2006-BLA-06184

In the Matter of:

STEVEN MULLINS,
Claimant,

v.

PEN COAL CORP.,
Employer,

and

WEST VIRGINIA CWP FUND,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Leonard Stayton, Esq.
Inez, Kentucky
For the Claimant

Allison B. Moreman
Jackson Kelly PLLC
Lexington, Kentucky
For the Employer

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS ON REMAND

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 (hereinafter referred to as “the Act”) and the regulations promulgated thereunder, located in Title 20 of the Code of Federal Regulations.¹

Procedural History

The claimant, Steven Mullins (“Claimant”), filed this initial claim for benefits on March 18, 2005.² (DX 2). On June 1, 2006, the district director denied benefits in a Proposed Decision and Order. (DX 31). Claimant requested a formal hearing, and the claim was forwarded to the Office of Administrative Law Judges. (DX 33, 35). I held a hearing on June 25, 2008, in Prestonburg, Kentucky. By Decision and Order issued November 19, 2009, I denied Claimant benefits.³ Claimant appealed to the Benefits Review Board (“Board”). On January 20, 2011, the Board affirmed in part, reversed in part, and remanded the claim.⁴ The Board affirmed the undersigned’s findings that total disability was established pursuant to § 718.204(b); and that the evidence is insufficient to establish the existence of pneumoconiosis pursuant to § 718.202(a)(1)-3).⁵ However, the Board provided the following guidance on remand:

1. Consider whether Claimant has established the requisite fifteen years of qualifying coal mine employment to establish invocation of the Section 411(c)(4) presumption;
2. Provide a more detailed explanation of my credibility determination regarding Dr. Gaziano’s opinion on legal pneumoconiosis;
3. Reconsider all of the medical opinion evidence relevant to the existence of legal pneumoconiosis;
4. Reconsider the CT scan readings of Drs. Repsher and Alexander, including the relative profession credentials of the physicians providing the readings, and determine whether they support a finding of pneumoconiosis pursuant § 718.107.⁶

The enactment of the PPACA during the pendency of Claimant’s appeal to the Board caused the length and nature of Claimant’s coal mine employment to be of substantially greater legal significance than it was at the time of the hearing. Thus, the undersigned issued an Order on June 13, 2013, reopening the record on remand and allowing the parties to submit additional information on the issue. According to my Order, the parties were permitted to submit additional documentary evidence; however, “[s]uch additional evidence shall be limited to addressing the

¹ 30 U.S.C. § 901, *et seq.*

² Claimant’s most recent coal mine employment occurred in West Virginia. Thus, the law of the United States Court of Appeals for the Fourth Circuit applies to this claim. *BRB Remand Order*, at 3 n.4; *see Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989).

³ *Mullins v. Pen Coal Corp.*, 2006-BLA-06184 (ALJ November 19, 2009) (hereinafter *ALJ D&O*).

⁴ *Mullins v. Pen Coal Corp.*, BRB No. 10-0214 BLA slip op. (Jan. 20, 2011) (unpub.) (hereinafter *BRB Remand Order*).

⁵ *BRB Remand Order*, at 2, 7.

⁶ *Id.* at 4-8.

length of Claimant's coal mine employment history and whether his coal mine employment was underground or in conditions substantially similar to those found in underground mines.”

In response to my Order, Employer submitted a supplemental medical report by Dr. Abdul Dahhan dated July 3, 2013. As this medical report does not address the length or nature of Claimant's coal mine employment, it is beyond on the scope of evidence permitted by my Order and will not be accepted into the record. Thus, it will not be considered.

On August 1, 2013, Claimant filed a Motion for Extension of Time to File Evidence Concerning Claimant's Employment History in which he sought an additional twenty days to submit evidence. However, on September 18, 2013, Claimant's counsel filed a letter dated September 16, 2013, stating that Claimant is “not able to establish at least 15 years of coal mine employment. Accordingly, it does not appear that the presumption present at 30 U.S.C. § 921(c)(4) applies to this claim.” Thus, I will consider Claimant's request for additional time to be withdrawn. The record is hereby closed, and the case is ready for decision. The parties have not filed briefs on remand.

Based on a thorough analysis of the entire record in this case, and with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, case law, and the Board's Decision and Order, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Summary of the Evidence

The Board did not disturb any the undersigned's summarizations of the medical evidence as contained in my Decision and Order issued November 19, 2009.⁷ Therefore, I hereby adopt and incorporate as if fully stated herein my summaries of the medical evidence in this case, except to the extent that any findings or conclusions made in my prior Decision and Order are inconsistent with those expressed in this Decision and Order on Remand.⁸ However, based on the Board's instructions, this Decision depends largely on the weight to be accorded to Dr. Gaziano's medical opinion relative to the contrary opinions of Drs. Repsher and Dahhan. Thus, I will include summaries of their medical opinions in this Decision.⁹

In my prior Decision and Order, I summarized the medical opinion evidence, as follows:

1. Medical Opinion of Dr. Gaziano (DX 12 and EX 6)

Dominic J. Gaziano, M.D., who is a B-reader, Board-certified in internal medicine, with a subspecialty in pulmonary disease, examined Claimant for his Department-sponsored pulmonary examination on May 5, 2005. (DX 12). He obtained an employment and medical history, and recorded Claimant's symptoms and examination findings. He considered a coal mine employment history of

⁷ BRB Remand Order.

⁸ ALJ D&O.

⁹ BRB Remand Order, at 5 n.5.

16 years, underground as a roof bolter, and a smoking history of one pack of cigarettes per day for the past 23 years. An x-ray was negative for pneumoconiosis, but showed scattered calcified granuloma. A pulmonary function test revealed moderate obstructive ventilatory impairment. An arterial blood gas test revealed normal rest and exercise levels.

Dr. Gaziano diagnosed legal pneumoconiosis and chronic obstructive pulmonary disease. He categorized Claimant's pulmonary impairment as "moderate impairment" due to "16 year coal mining work and 23 pack-year smoking history." In Dr. Gaziano's opinion, Claimant does not have the respiratory capacity to perform his last work as a coal miner or other comparable work.

Dr. Gaziano testified in a deposition taken on June 16, 2009, and confirmed the earlier diagnosis of legal pneumoconiosis and COPD caused by coal dust and cigarette smoking. (EX 6). He testified that this diagnosis was based on Claimant's significant exposure to coal dust during his 16-year work history. Dr. Gaziano also testified that Claimant's smoking was significant in the diagnosis. When asked whether he was able to determine the extent to which smoking and coal dust exposure contributed to Claimant's impairment, Dr. Gaziano testified that he could not differentiate the cause when the effect is the same.

2. Medical Opinion of Dr. Repsher (DX 29 and EX 2)

Lawrence H. Repsher, M.D., who is a B-reader, Board-certified in internal medicine, with a subspecialty in pulmonary disease, examined Claimant on March 29, 2006. (DX 29). He obtained an employment and medical history, and recorded Claimant's symptoms and examination findings. He considered a coal mine employment history of 14 years, underground as a roof bolter and buggy operator, and a smoking history of more than two packs of cigarettes per day for 23 years (carboxyhemoglobin levels indicated a two and a half to three pack per day cigarette smoking habit). An x-ray was negative for pneumoconiosis, but showed hyperinflation and emphysema. A pulmonary function test revealed COPD with an asthmatic component, although Dr. Repsher noted that interpretation was difficult because of underlying vocal cord dysfunction syndrome. An arterial blood gas test was normal. Physical examination of Claimant's chest revealed no rales or rhonchi, although the doctor noted inspiratory and expiratory wheezes, even with quiet breathing. A CT scan showed a noncalcified six mm nodule in the superior segment of the right lower lobe. A resting electrocardiogram was consistent with COPD.

Dr. Repsher diagnosed COPD, with a bronchospastic component. He opined that Claimant does not suffer from coal workers' pneumoconiosis or any condition attributable to the inhalation of coal dust. He discussed several reasons for this opinion: negative x-ray evidence, lack of biopsy evidence, no pulmonary function evidence of pneumoconiosis, and normal arterial blood gas levels. In addition,

Dr. Repsher discussed cigarette smoking in connection with statistical rates of COPD in smokers and coal miners, concluding that “in this individual coal miner, to an overwhelming probability, any detectable COPD would be the result of cigarette smoking and/or asthma, but not the result of the inhalation of coal mine dust.” He also attached seven published medical papers discussing lung disease in coal miners.

Dr. Repsher testified in a deposition taken on October 15, 2007, and confirmed the earlier diagnosis of COPD. (EX 2). Regarding the issue of coal workers’ pneumoconiosis, he testified as follows:

[Claimant] doesn’t have clinical or medical pneumoconiosis because his chest x-ray and CT scans are negative, and we don’t have any autopsy or lung biopsy material to look at for histologic medical coal workers’ pneumoconiosis. And he doesn’t have legal coal workers pneumoconiosis because he doesn’t have airways obstruction, at least documented airways obstruction, and does not have evidence of any other intrinsic lung disease.

The doctor rated Claimant’s pulmonary capacity as normal, testifying that Claimant “could do continuous heavy labor.”

3. Medical Opinion of Dr. Dahhan (EX 1 and EX 4)

Abdul K. Dahhan, M.D., who is a B-reader, Board-certified in internal medicine, with a subspecialty in pulmonary disease, examined Claimant on September 22, 2007 and submitted a report dated September 24, 2007. (EX 1). He obtained an employment and medical history and recorded Claimant’s symptoms and examination findings. He considered a coal mine employment history of 18 years, underground as a roof bolter and buggy operator, and a smoking history of one-and-a-half packs per day for the past 24 years (carboxyhemoglobin level indicated a half pack per day cigarette smoking habit). An x-ray was negative for pneumoconiosis. A pulmonary function test revealed moderately severe obstructive ventilatory impairment with no evidence of restrictive defect. An arterial blood gas test was normal. Electrocardiogram showed regular sinus rhythm with normal tracings.

Dr. Dahhan diagnosed a moderate obstructive ventilatory impairment. Citing several reasons for his opinion, Dr. Dahhan stated that the ventilatory impairment resulted from Claimant’s “lengthy smoking habit.” Specifically, the doctor opined:

[Claimant] is being treated with multiple bronchodilator agents indicating that his physician believes that his obstruction is not fixed, a finding that is inconsistent with the permanent adverse affects of coal dust on the respiratory system; reversibility of his

airway obstruction cannot be determined due to poor performance on post bronchodilator studies; he has lost over 1500cc of his FEV1, an amount of loss that cannot be accounted for by the obstructive impact of coal dust on the respiratory system[.]

Dr. Dahhan also testified in a deposition taken on October 10, 2007. (EX 4). Before his deposition, Dr. Dahhan reviewed additional medical records, including Dr. Gaziano's Department of Labor exam report, Dr. Repsher's report, and Dr. Wiot's x-ray reading. Dr. Dahhan confirmed his earlier diagnosis and explained that Claimant "has airway obstruction severe enough to render him disabled from performing mild to moderate physical[] jobs," which would include his prior coal mining jobs. But the doctor testified that there was no evidence of pneumoconiosis because Claimant's chest x-ray was clear. Instead, Dr. Dahhan attributed Claimant's respiratory impairment to smoking, citing the same reasons discussed in his medical report. Regarding the medical records, Dr. Dahhan testified that they complemented and supported his diagnosis.¹⁰

Law and Analysis

I. Length of Coal Mine Employment

While Claimant's case was pending before the Board, the Patient Protection and Affordable Care Act ("PPACA") was signed into law.¹¹ Section 1556 of the PPACA revived the fifteen-year presumption at 30 U.S.C. § 921(c)(4) of the Act, for claims filed after January 1, 2005, and pending on or after March 23, 2010.¹² Claimant filed this claim on March 18, 2005, and the claim was pending on March 23, 2010. (DX2). Thus, the revived fifteen-year presumption will apply to this claim if Claimant establishes fifteen or more years of qualifying coal mine employment and a totally disabling pulmonary or respiratory impairment.¹³ Although the parties stipulated that Claimant worked in coal mine employment for eleven years, the Board instructed me to reconsider the length and nature of Claimant's coal mine employment history, in light of the potential applicability of the revived presumption of disability due to pneumoconiosis.¹⁴

By letter dated September 16, 2013, Claimant conceded that he "is not able to establish at least fifteen years of coal mine employment. Accordingly, it does not appear that the presumption present at 30 U.S.C. § 921(c)(4) applies to this claim." Having reviewed the relevant evidence of record, I find that the record supports a finding that Claimant worked in coal mine employment for eleven years. Accordingly, I again accept the parties' stipulation that Claimant has a coal mine employment history of eleven years.

¹⁰ *ALJ D&O*, at 5-7.

¹¹ Pub. L. No. 111-148, § 1556 (2010).

¹² *Id.*

¹³ § 718.305

¹⁴ *BRB Remand Order*, at 7.

II. Existence of Pneumoconiosis

“Pneumoconiosis” is defined by the Act as “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.”¹⁵ This definition encompasses two forms of lung disease, “clinical pneumoconiosis” and “legal pneumoconiosis.”¹⁶ “Clinical pneumoconiosis” consists of:

those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.¹⁷

Clinical pneumoconiosis is “generally visible on chest x-ray films.”¹⁸

“Legal pneumoconiosis” is more broadly defined to include “any chronic [restrictive or obstructive] pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”¹⁹ Significantly, “[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act.”²⁰ Legal pneumoconiosis “encompasses a broader spectrum of diseases than those pathologic conditions which can be detected by clinical diagnostic tests such as x-rays or CT scans.”²¹ Thus, an x-ray read as negative for pneumoconiosis should not necessarily be treated as evidence weighing against a finding of legal pneumoconiosis.²²

Section 718.202 provides four means by which pneumoconiosis may be established: chest x-ray evidence, biopsy evidence, autopsy evidence, or a physician’s reasoned medical opinion.²³ Where applicable, a claimant may also rely on one of the presumptions found at 20 C.F.R. §§ 718.304, 718.305, or 718.306.²⁴ In addition to these four means, 20 C.F.R. § 718.107(a) provides that the results of any other medically acceptable test or procedure that tends to demonstrate the presence or absence of pneumoconiosis, “shall be given appropriate consideration.” In cases arising within the Fourth Circuit, pneumoconiosis must be established by a preponderance of the evidence in all four categories; an administrative law judge may not look exclusively to one of 20 C.F.R. § 718.202(a)’s four subsections, while ignoring contrary evidence from one of the other three subsections. *Collins v. Pond Creek Mining Co.*, 468 F.3d 213, 218-19 (4th Cir. 2006) (*citing Compton*, 211 F.3d at 207-08).

¹⁵ 30 U.S.C. § 902(b); *see also* 20 C.F.R. § 718.201(a); 725.101(a)(25).

¹⁶ 20 C.F.R. § 718.201(a); 65 Fed. Reg. 79,920, 79,937 (Dec. 20, 2000).

¹⁷ 20 C.F.R. § 718.201(a)(1).

¹⁸ *Id.*; *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 210 (4th Cir. 2000).

¹⁹ 20 C.F.R. § 718.201(a)(2) and (b).

²⁰ *Martin v. Ligon Preparation Co.*, 400 F.3d 302, 306 (6th Cir. 2005).

²¹ 65 Fed. Reg. at 79,945.

²² *Compton*, 211 F.3d at 210.

²³ 20 C.F.R. § 718.202(a).

²⁴ *Id.*

A. X-ray Evidence

A chest x-ray conducted and classified in accordance with the regulations may form the basis for a finding of pneumoconiosis.²⁵ When two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays.²⁶ The administrative law judge may defer to the numerical superiority of the x-ray readings, or to readings by physicians who are both B-readers and Board-certified radiologists.²⁷ No claim may be denied solely on the basis of chest x-ray evidence.²⁸

In my Decision and Order issued November 19, 2009, I found that the weight of the x-ray evidence did not support a finding of clinical pneumoconiosis. The Board affirmed my finding.²⁹ Thus, I adhere to my conclusion that the x-ray evidence does not support a finding of clinical pneumoconiosis pursuant to § 718.202(a)(1).

B. Autopsy/Biopsy Evidence

A biopsy or autopsy conducted and reported in compliance with the regulations may also form the basis for a finding of pneumoconiosis.³⁰ Autopsy and biopsy reports are generally considered to be the most reliable evidence of the existence of pneumoconiosis. *Gray v. SLC Coal Co.*, 176 F.3d 382, 387 (6th Cir. 1999); *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). Because the record in this case contains no biopsy or autopsy evidence, Claimant has not established the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(2).

C. Statutory Presumptions

Three statutory presumptions, found in 20 C.F.R. §§ 718.304, 718.305, and 718.306, are available to aid a claimant in establishing pneumoconiosis.³¹ Section 718.305 applies only to claims in which the miner worked more than fifteen years in qualifying coal mine employment, while section 718.306 applies only to survivor's claims in which the miner died on or before March 1, 1978. Neither presumption is applicable here. Section 718.304 sets forth the criteria for establishing the existence of complicated pneumoconiosis. The record in this claim contains no evidence of complicated pneumoconiosis. As a result, Claimant has not established the existence of pneumoconiosis by use of the presumptions listed at 20 C.F.R. § 718.202(a)(3).

D. Medical Opinions

A finding of pneumoconiosis may also be based upon a physician's documented and reasoned medical opinion.³² A "documented" opinion is one that sets forth the clinical findings,

²⁵ 20 C.F.R. § 718.202(a)(1).

²⁶ *Id.*

²⁷ *See Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123, 1-138 (2006); *Staton v. Norfolk & Western Ry. Co.*, 65 F.3d 55, 60 (6th Cir. 1995).

²⁸ 20 C.F.R. § 718.202(b).

²⁹ *BRB Remand Order*, at 2 n.1.

³⁰ 20 C.F.R. § 718.202(a)(2).

³¹ 20 C.F.R. § 718.202(a)(3).

³² 20 C.F.R. § 718.202(a)(4).

observations, facts, and other data upon which the physician based the diagnosis.³³ An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories.³⁴ A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions.³⁵ Whether a medical report is sufficiently documented and reasoned is for the judge as the finder-of-fact to decide.³⁶ Although the claimant bears the burden of proof in establishing legal pneumoconiosis, this burden is not heavy.³⁷

When weighing conflicting medical reports, the administrative law judge must address the comparative credentials of the respective physicians, the explanations for their conclusions, the documentation underlying their medical judgments, and the sophistication of and bases for their diagnoses.³⁸ The record includes three medical opinions on the issue of whether Claimant suffers from legal pneumoconiosis.

Dr. Gaziano

Dr. Gaziano was the only doctor to diagnose legal pneumoconiosis, finding that Claimant suffers from COPD caused by cigarette smoking and coal dust exposure. Because Dr. Gaziano testified that he based this diagnosis on Claimant's work history, symptoms, and examination findings, the opinion is well-documented. Dr. Gaziano found that Claimant's COPD was partially caused by coal dust, reporting and testifying that Claimant "had a significant exposure to both coal and sand or silica dust of sixteen years." (DX 12; EX 6 at 11).

However, Dr. Gaziano relied on a coal mine employment history of sixteen years; whereas, the parties have stipulated that Claimant worked in coal mine employment for only eleven years. The Board instructed me to reevaluate my finding that Dr. Gaziano's opinion was entitled to little probative weight on the issue of legal pneumoconiosis due to his misunderstanding of the length of Claimant's coal mine employment history.³⁹

The Board explained that, under *Worhach v. Director, OWCP*, an administrative law judge may discredit a physician who diagnosed pneumoconiosis when the physician relied on an inaccurate length of coal mine employment.⁴⁰ However, the Board cautioned that *Worhach* should not be mechanically applied.⁴¹

The Board found persuasive Claimant's argument that my finding of eleven years equaled 69% of the years of coal mine employment relied on by the physicians and remained "significantly greater than the ten years of coal mine employment which is generally found to be

³³ *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987).

³⁴ *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1984).

³⁵ *Fields*, 10 B.L.R. 1-19.

³⁶ *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc).

³⁷ *D.H. v. Old Ben Coal Co.*, B.R.B. No. 08-0391 B.L.A. (Dec. 16, 2008).

³⁸ See *J.V.S. v. Arch of West Virginia*, 24 B.L.R. 1-78, 1-96 (2008).

³⁹ *BRB Remand Order*, at 4.

⁴⁰ *Id.* (citing *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993)).

⁴¹ *Id.* at 4.

a sufficient length of coal mine employment to contribute to a miner's pulmonary impairment pursuant to 20 C.F.R. § 718.203(b)."⁴² The Board held that I "did not adequately explain how the five year discrepancy between the sixteen years of coal mine employment relied upon by Dr. Gaziano and the eleven years credited by the administrative law judge, undermined the credibility of Dr. Gaziano's opinion finding legal pneumoconiosis."⁴³

Dr. Gaziano relied upon his understanding that Claimant worked in coal mine employment for sixteen years. I have again found that Claimant worked in coal mine employment for eleven years. Upon further reflection of the record before me, I now find that the difference between sixteen and eleven years is insufficient to undermine the credibility of Dr. Gaziano's opinion that Claimant suffers from legal pneumoconiosis.

Dr. Gaziano interpreted Claimant's pulmonary function test dated May 5, 2005, as revealing a "moderate impairment." (DX 14, 12 at 3, 5). Based on the results of the PFT, Dr. Gaziano diagnosed Claimant with "statutory CWP" and chronic obstructive pulmonary disease ("COPD"). (DX 12 at 4-5). Dr. Gaziano attributed Claimant's obstructive impairment to sixteen years of coal mine employment and twenty-three years of smoking history. (DX 12, EX 6 at 11). In *Cornett v. Benham Coal, Inc.*, the Sixth Circuit held that a physician's opinion that the miner's "obstructive ventilatory defect could have been caused by either smoking or coal dust exposure" should be viewed under the circumstances of that case as "tantamount to a finding that both coal dust exposure and smoking were operative factors and that it was impossible to allocate blame between them."⁴⁴ The Court emphasized that such a finding was sufficient to establish that the miner's pneumoconiosis arose out of his coal mine employment, stating that:

[U]nder the statutory definition of pneumoconiosis, Cornett was not required to demonstrate that coal dust was the *only* cause of his current respiratory problems. He needed only show that he has a chronic respiratory and pulmonary impairment 'significantly related to, or substantially aggravated by, dust exposure in coal mine employment.'⁴⁵

Dr. Gaziano's opinion regarding Claimant's COPD is supported by the results of his own objective medical testing, and accounts for Claimant's coal dust exposure, without ignoring his significant smoking history. Accordingly, I find Dr. Gaziano's diagnosis of COPD, caused in part by coal dust exposure, is a reasoned and documented diagnosis of legal pneumoconiosis, and I give his opinion full probative weight on that issue.

Dr. Repsher

Dr. Repsher opined that Claimant does not suffer from clinical or legal pneumoconiosis. (DX 29 at 7, EX 2 at 25). Dr. Repsher initially diagnosed Claimant with COPD, with a bronchospastic component based on the results of the PFT dated March 29, 2006, which he interpreted as revealing "only pure and partially reversible obstructive lung disease."

⁴² *Id.* (internal quotation marks omitted).

⁴³ *Id.*

⁴⁴ *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

⁴⁵ *Id.* at 576 (citing 20 C.F.R. § 718.201).

(DX 29 at 7). However, Dr. Respher also stated that interpretation of the PFT dated March 29, 2006, was “rendered difficult, because of underlying vocal cord dysfunction syndrome.” (EX 29 at 6).

According to Dr. Respher, Claimant’s COPD was not caused by or aggravated by his employment in coal mining or exposure to coal mine dust. (*Id.*). Rather, Dr. Repsher attributed Claimant’s COPD to his history of heavy cigarette smoking and concluded that Claimant’s PFT was “consistent with COPD with an asthmatic component.” (DX 29 at 6-7). However, during his deposition, Dr. Repsher testified that interpretation of the spirometry portion of the PFT dated March 29, 2006, was “difficult if not impossible.” (EX 2 at 24). Thus, Dr. Repsher “ignore[d] the spirometry, the huff-and-puff part, because of vocal cord dysfunction” and concluded that Claimant “doesn’t have any objective evidence of airways obstruction. It may be that he has some, but we can’t really determine that because of his vocal cord dysfunction syndrome.” (EX 2 at 24-25). Based on his conclusion that there was no evidence that Claimant suffers from an airway obstruction, Dr. Respher then posited that there was no evidence of any intrinsic lung disease. (EX 25-26). However, Dr. Repsher failed to explain the change in his position regarding whether the PFT dated March 29, 2006, was a reliable indicator of whether Claimant suffers from an obstructive impairment. A medical opinion that is internally inconsistent may be entitled to little probative weight.⁴⁶

Dr. Repsher’s opinion is also based on an inaccurate smoking history. I have found Claimant’s smoking history to be approximately 26 pack-years, based on one pack per day since 1983. In contrast, Dr. Repsher testified that he based his opinion on a smoking history of two-and-one half to three packs per day based on the results of carboxyhemoglobin testing. (EX 2 at 23-24, DX 29 at 7). It is proper for a judge to discredit a medical opinion based on an inaccurate smoking history.⁴⁷

Dr. Repsher cited to seven published medical articles discussing lung disease in coal miners. (DX 29 at 24-88). According to Dr. Repsher, this research establishes that there is no clinically significant presence of COPD in coal miners. In other words, Dr. Repsher opined that “the average loss of FEV₁ [in coal miners] is so small, that it is only a small fraction of the anticipated test to test and day-to-day variation from simply repeating the spirometry over and over again. Thus, each test result would be statistically the same number.” (DX 29 at 8). Based on this rationale, Dr. Respher concluded that “in [Claimant], to an overwhelming probability, any detectable COPD would be the result of cigarette smoking and/or asthma, but not the result of the inhalation of coal mine dust.” (*Id.*). Rather than providing reasons why coal dust did not cause Claimant’s impairment, Dr. Repsher merely opines that clinically significant COPD caused by coal dust exposure “would be very unlikely in this specific individual miner.” (*Id.*). Dr. Respher’s opinion is based on generalities and statistical probabilities, instead of specifically focusing on Claimant’s condition. A medical opinion based on generalities, rather than specifically focusing upon the miner’s condition, may be rejected.⁴⁸ For the aforementioned reasons, I find that Dr. Repsher’s opinion on the issue of whether Claimant suffers from pneumoconiosis is entitled to little probative weight.

⁴⁶ *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986).

⁴⁷ *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

⁴⁸ *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985); *see also Consolidation Coal Co. v. Director, OWCP [Beeler]*, 521 F.3d 723 (7th Cir. 2008).

Dr. Dahhan

Dr. Dahhan opined that Claimant “has airway obstruction severe enough to render him disabled from performing mild to moderate physical[] jobs,” which would include his prior coal mining jobs. (EX 4). However, Dr. Dahhan attributed Claimant’s impairment entirely to his history of smoking and not to coal dust exposure. (EX 1 at 3, EX 4 at 17-18). Dr. Dahhan offered several explanations for his conclusion that Claimant’s pulmonary impairment is unrelated to his history of coal dust exposure, none of which I find persuasive.

First, Dr. Dahhan concluded that because Claimant was prescribed bronchodilators by his treating physician, “his physician believes that his obstruction is not fixed, a finding that is inconsistent with the permanent adverse [e]ffects of coal dust on the respiratory system.” (EX 1 at 3). In *Consolidation Coal Co. v. Swiger*,⁴⁹ the evidence showed that when the miner was given bronchodilator medication, his pulmonary condition improved, but the residual impairment that remained was still disabling. Although the miner’s condition improved, “the fact that he experienced a disabling residual impairment suggested that a combination of factors [caused] his pulmonary condition.”⁵⁰ Here, as in *Consolidation Coal*, Dr. Dahhan reported an improvement in Claimant’s post-bronchodilator results, but the results were qualifying both pre- and post-bronchodilator. This suggests that a combination of factors caused his pulmonary condition. The fact that Claimant uses bronchodilators does not necessarily rule out the existence of legal pneumoconiosis, and Dr. Dahhan did not adequately explain how he concluded that it does in this case.

Additionally, Dr. Dahhan concluded that because Claimant “has not had any exposure to coal dust for three years,” “any industrial bronchitis he might have had would have ceased.” (EX 4 at 18). This rationale fails to address the potential for latency and progressivity and is at odds with the Department of Labor’s determination that coal mine dust exposure can cause a chronic pulmonary impairment after a latent period.⁵¹

Dr. Dahhan also posited that Claimant has “lost over 1500 cc of his FEV1, an amount of loss that cannot be accounted for by the obstructive impact of coal dust on the respiratory system.” (EX 1 at 3). Again, Dr. Dahhan does not explain why both coal mine dust and cigarette smoking could not have contributed to Claimant’s pulmonary impairment. His opinion that coal dust, alone, could not have caused such a substantial decrease in pulmonary function does not speak to whether Claimant’s impairment was “significantly related to, or substantially aggravated by” his coal mine employment.⁵² For these reasons, I find that Dr. Dahhan’s opinion regarding the cause of Claimant’s chronic obstructive pulmonary impairment is not well-reasoned. Accordingly, I give his opinion little probative weight on the issue of legal pneumoconiosis.

For the reasons discussed above, I find that Dr. Gaziano’s opinion is well-reasoned, well-documented, and entitled to full probative weight on the issue of legal pneumoconiosis. I also find that the opinions of Drs. Repsher and Dahhan are inadequately reasoned and thus, are

⁴⁹ 98 Fed. Appx. 227, 238 (4th Cir. 2004).

⁵⁰ *Id.*

⁵¹ See 20 C.F.R. § 718.201(c); 65 Fed. Reg. 79,920, 79,971 (Dec. 20, 2000); *E.B. v. Consolidation Coal Co.*, BRB No. 08-0294 (Jan. 7, 2009).

⁵² 20 C.F.R. § 718.201(b).

entitled to little probative weight on the issue. Accordingly, I find that the preponderance of the medical opinion evidence supports a finding of legal pneumoconiosis pursuant to § 718.202(a)(4).

None of the physicians who offered medical opinions in this claim opined that Claimant suffers from clinical pneumoconiosis. Dr. Gaziano interpreted the chest x-ray dated May 5, 2005, as negative for clinical pneumoconiosis but did not otherwise offer an opinion on the issue of clinical pneumoconiosis. (DX 10, DX 12 at 3). Dr. Respher opined that Claimant does not have clinical pneumoconiosis based on his negative readings of the x-ray and CT scan dated March 29, 2006. (EX 29 at 7). However, as will be discussed below, I now find that the CT scan dated March 29, 2006, is positive for clinical pneumoconiosis. It is proper to accord less weight to a physician's opinion that is based on a premise contrary to the administrative law judge's finding.⁵³ Dr. Dahhan opined that Claimant "has insufficient objective findings to justify the diagnosis of clinical pneumoconiosis based on the negative chest x-ray." (EX 1 at 2). The Board permits the discrediting of physician opinions amounting to no more than x-ray reading restatements.⁵⁴ Acknowledging that Dr. Dahhan performed other physical and objective testing, he stated in his medical report that he relied on a negative x-ray in concluding that Claimant does not suffer from clinical pneumoconiosis. Thus, I find that none of the submitted medical reports contain a well-reasoned and well-documented opinion of the issue of clinical pneumoconiosis. Accordingly, I find that the medical opinion evidence neither supports nor refutes a finding of clinical pneumoconiosis pursuant to § 718.202(a)(4).

E. Other Medical Evidence

A finding of pneumoconiosis may also be based upon any other "medically acceptable test or procedure reported by a physician."⁵⁵ The party submitting the evidence must demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claim for benefits.⁵⁶

The record in this claim contains CT scan interpretations by Drs. Repsher and Alexander of a CT scan dated March 29, 2006. (CX 3; DX 29; EX 2). In my previous Decision and Order, I found that only Dr. Repsher's interpretation of this CT scan was admissible, as Dr. Alexander did not demonstrate that CT scans are medically acceptable for the evaluation of pulmonary disease.⁵⁷ On remand, the Board has instructed me to reconsider the CT scan interpretations of both Dr. Alexander and Dr. Repsher.⁵⁸ In so doing, I will consider the physicians' relative credentials to determine whether the CT scan evidence is sufficient to support a finding that Claimant suffers from pneumoconiosis pursuant to § 718.107.

⁵³ See *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (finding that the ALJ must consider whether a physician who based his diagnosis on a positive x-ray should be given less weight because the x-ray was later interpreted as negative by a physician of higher qualifications).

⁵⁴ See *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-1405 (1985)).

⁵⁵ 20 C.F.R. § 718.107(a).

⁵⁶ 20 C.F.R. § 718.107(b).

⁵⁷ *ALJ D&O*, at 13.

⁵⁸ *BRB Remand Order*, at 6.

Dr. Repsher read the CT scan and found no evidence of coal workers' pneumoconiosis, although he noted "a noncalcified 6 mm nodule probably in the superior segment of the right lower lobe." (DX 29; EX 2). Dr. Alexander, however, did find evidence of simple coal workers' pneumoconiosis, reporting innumerable round opacities measuring up to 1.45 mm present in both lungs. (CX 3). An administrative law judge may give more weight to a CT scan reading based on the reader's superior qualifications.⁵⁹ Dr. Alexander is Board-certified in Diagnostic Radiology and Nuclear Medicine and is a B-reader. (CX 4). Dr. Respher is a B-reader.⁶⁰ Because Dr. Alexander is Board-certified in Radiology and thus has superior credentials in CT scan interpretation, I give his opinion regarding the CT scan greater probative weight. Thus, I find that the CT scan dated March 29, 2006, is positive for clinical pneumoconiosis. Accordingly, I find that the CT scan evidence supports a finding of clinical pneumoconiosis pursuant to § 718.107.

F. Pneumoconiosis Conclusion

With regard to clinical pneumoconiosis, the preponderance of the x-ray evidence is negative for clinical pneumoconiosis, but the CT scan evidence is positive for the disease. There is no autopsy or biopsy evidence, and none of the statutory presumptions apply. I have found none of the medical opinions to be adequately reasoned on the issue. Thus, giving the most weight to the positive CT scan and noting the absence of a well-reasoned and well-documented medical report, I find that Claimant has established by a preponderance of the evidence that he suffers from clinical pneumoconiosis pursuant to § 718.202(a).

With regard to legal pneumoconiosis, I have found Dr. Gaziano's opinion that Claimant suffers from the condition, well-reasoned, well-documented and entitled to full probative weight on the issue. I have found the opinions of Drs. Dahhan and Respher insufficiently reasoned and thus, entitled to little probative weight. Accordingly, giving the most weight to Dr. Gaziano's well-reasoned and well-documented opinion, I find that Claimant has established by a preponderance of the evidence that he suffers from legal pneumoconiosis pursuant to § 718.202(a).

III. Causation of Pneumoconiosis

A miner who suffers from pneumoconiosis must also establish that the pneumoconiosis arose, at least in part, out of coal mine employment.⁶¹ If a miner who is suffering or suffered

⁵⁹ *BRB Remand Order*, at 6 (citing *Sewell Coal Co. v. Director, OWCP [Dempsey]*, 523 F.3d 257, 24 B.L.R. 2-128 (4th Cir. 2008)).

⁶⁰ A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their x-ray interpretations may be given more weight than those of other physicians. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). However, a B-reader has not necessarily demonstrated proficiency in assessing and interpreting CT scan evidence of pneumoconiosis.

⁶¹ 20 C.F.R. § 718.203(a).

from pneumoconiosis was employed for ten or more years in one or more coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.⁶²

Here, the presumption is applicable, and Employer has offered no evidence that Claimant's pneumoconiosis did not arise out of his coal mine employment. In my initial Decision and Order, I found that Claimant could not establish this element because he failed to establish that he suffers from pneumoconiosis, a finding that is contrary to my conclusion on remand.⁶³ Accordingly, because Claimant worked in coal mine employment for more than ten years and Employer has offered no evidence that his pneumoconiosis did not arise out of coal mine employment, I find that Claimant has established that his pneumoconiosis arose out of his coal mine employment.

IV. Total Disability

In my initial Decision and Order, I found that Claimant was totally disabled by a pulmonary or respiratory impairment pursuant to § 718.204(b)(2), and the Board affirmed my finding.⁶⁴ I hereby adhere my finding that Claimant has established by a preponderance of the evidence that he is totally disabled by a pulmonary or respiratory impairment as defined in § 718.204(b).

V. Total Disability due to Pneumoconiosis

The regulations state that a miner "shall be considered totally disabled due to pneumoconiosis if pneumoconiosis . . . is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment."⁶⁵ Pneumoconiosis is considered a "substantially contributing cause" of the miner's disability if it:

- (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
- (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.⁶⁶

Dr. Gaziano diagnosed Claimant with a totally disabling obstructive impairment which he attributed both to Claimant's history of coal dust exposure and extensive smoking history. (DX 12 at 4-5; EX 6 at 11). Moreover, when asked at his deposition to identify the basis for his decision to attribute Claimant's COPD to legal pneumoconiosis, he replied "Well, that obstructive breathing impairment is a part of disease of coal miners, underground miners, and that he had a significant exposure to both coal and sand or silica dust of sixteen years. . . ." (EX 6 at 11). I have found Dr. Gaziano's opinion regarding legal pneumoconiosis to be well-reasoned and well-documented. His opinion is based on objective medical testing, his clinical examination and evaluation of Claimant, and Claimant's smoking and occupational

⁶² 30 U.S.C. § 921(c)(1); 20 C.F.R. § 718.203(c).

⁶³ *ALJ D&O*, at 14.

⁶⁴ *ALJ D&O*, at 14-17; *BRB Remand Order*, at 7.

⁶⁵ § 718.204(c)(1).

⁶⁶ *Id.*

histories. Accordingly, I give full probative weight to Dr. Gaziano's opinion regarding total disability due to pneumoconiosis.

Drs. Repsher and Dahhan both opined that Claimant does not suffer from pneumoconiosis. Dr. Repsher also concluded that Claimant is not totally disabled by a pulmonary or respiratory impairment. It is proper for an administrative law judge to discount a physician's negative opinion on causation of a miner's disability when that opinion is based on an erroneous assumption that the miner does not have pneumoconiosis.⁶⁷ Accordingly, I give little weight to their opinions on the issue of whether Claimant's totally disabling respiratory or pulmonary impairment is due to pneumoconiosis.

Thus, I give the most weight to Dr. Gaziano's well-reasoned and well-documented opinion that Claimant is totally disabled due to pneumoconiosis. Accordingly, I find that Claimant has established by a preponderance of the evidence that he his total disability is due to pneumoconiosis pursuant to § 718.204(c).

Entitlement

Based on the findings in this case as discussed above, Claimant has met all of the conditions of entitlement. Therefore, his claim for benefits under the Act is granted.

Section 725.503(b) provides that benefits are payable to a miner who is entitled beginning with the month of the onset of total disability due to pneumoconiosis. Where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed. The record in this case does not contain any medical evidence establishing exactly when Claimant became totally disabled. Entitlement of benefits is established as of March 2005, the month and year in which Claimant filed this claim for benefits.

Attorney Fees

The Act provides for the award of fees and costs to a successful claimant's attorney.⁶⁸ Claimant's counsel shall have thirty days to submit an application for attorney fees and costs incurred in this claim. The application must conform to 20 C.F.R. § 725.365 and 725.366, and must be served upon all parties, including claimant and the Director, OWCP. Any objections to the fee application shall be filed within ten days of receipt. Counsel is prohibited by law from receiving any fee prior to approval of his or her application.

⁶⁷ *Amburgey v. Gum Branch Coal Co.*, BRB No. 11-0231 BLA slip op. at 5-6 (Dec. 15, 2011) (citing *Skukan v. Consolidated Coal Co.*, 993 F.2d 1228, 1233, 17 B.L.R. 2-97, 2-104 (6th Cir. 1993), *vacated sub nom.*, *Consolidated Coal Co. v. Skukan*, 512 U.S. 1231 (1994), *rev'd on other grounds*, *Skukan v. Consolidated Coal Co.*, 46 F.3d 15, 19 B.L.R. 2-44 (6th Cir. 1995); *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 17 B.L.R. 2-16 (6th Cir. 1993); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 116 19 B.L.R. 2-70, 2-83 (4th Cir. 1995); *Trujillo v. Kaiser Steel Corp.*, 8 B.L.R. 1-472, 1-473 (1986)).

⁶⁸ 30 U.S.C. § 932(a).

ORDER

IT IS HEREBY ORDERED:

1. The claim for benefits of claimant, Steven Mullins, is GRANTED;
2. Employer shall pay claimant all benefits to which he is entitled under the Act;
3. Employer shall reimburse the Black Lung Disability Trust Fund for all funds already paid to claimant; and
4. Employer shall pay claimant's attorney fees and expenses to be established in a supplemental decision and order.

JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board. To be timely, your appeal must be filed with the Board within thirty days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to: Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

